STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012007	A. BUILDING: _____ B. WING _____	C 03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING ASSISTED LIVING	2400 MARKET ST CHARLESTOWN, IN 47111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint #IN00145319. Complaint #IN00145319-Substantiated. No deficiencies related to the allegations are cited. Survey dates: March 12 and 13, 2014 Facility Number: 012007 Survey Team: Caitlin Lewis,RN-TC Gloria Reisert, MSW Census Bed Type: Residential: 101 Total:101 Census Payor Type: Medicaid: 85 Other:16 Total:101 Sample: 6 River Crossing Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00145319. Quality Review 03/14/14 by Lisa McColly	R 000		